STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165463	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestview Nursing & Rehab	2401 South Des Moines Street , Webster City, Iowa, 50595

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F0000 ✓	INITIAL COMMENTS Correction date: 11/20/25 The following deficiencies resulted from the facility's annual recertification survey conducted on September 15, 2025 - November 17, 2025. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F0550		

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F0550 SS = D	Continued from page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical record review, staff interview and policy review, the facility failed to treat residents (Resident #6 and Resident #18) with dignity during meal service. The facility reported a census of 58 residents. Findings Include: 1. The Minimum Data Set (MDS) dated 7/17/25 documented Resident #6 had a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment. The resident had diagnoses of other orthopedic conditions, cirrhosis, renal insufficiency and non-Alzheimer's dementia. The MDS documented the resident required substantial/maximal assistance with eating. The Care Plan for Resident #6, with a revision date of 10/7/24, included a focus area the resident will need help to complete Activities of Daily Living (ADL's) daily due to weakness. The Interventions instructed staff Resident #6 could eat independently after setting up. During a continuous observation of lunch service in the Chronic Confusion or Dementing Illness (CCDI) unit on 9/15/25 beginning at 12:00 PM, Staff C, Certified Nursing Assistant (CNA), stood over Resident #6 while helping her eat. Staff C brought bites of food on a fork to Resident #6's mouth and bringing the cup of fluid to the resident's mouth. Staff C did not sit next to the resident and stood over her for the entirety of the lunch service helping them eat. During an observation 9/16/25 at 11:45 AM of lunch service in the CCDI unit, Staff C stood over Resident #6 and brought food to their mouth on a fork. As Staff C assisted Resident #6 eat her lunch, they stood over her. 2. The MDS dated 7/2/25 documented Resident #18 had a BIMS score of 0, indicating severe cognitive impairment. The resident had diagnoses hyperlipidemia (high bad cholesterol) and non-Alzheimer's dementia.	F0550		

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F0550 SS = D	Continued from page 2 The MDS documented the resident required set-up or clean-up assistance with eating. The Care Plan for Resident #18, with a revision date of 10/7/22, included a focus area that the resident needed help to complete ADL's daily due to dementia. The Intervention instructed staff to set-up assist for eating and documented the resident as independent with eating. During a continuous observation of lunch service in the CCDI unit on 9/15/25 beginning at 12:08 PM, Staff D, CNA, stood over Resident #18 as they assisted them eat lunch. Staff D brought food to the resident's mouth with a fork and brought a cup with fluid to the resident's mouth. Staff D stood over the resident for the entire lunch service, assisting the resident with eating and drinking. During an observation 9/16/25 at 11:53 AM of lunch service in the CCDI unit, Staff C, CNA, went over to Resident #18, put food on a fork and brought it to their mouth, while standing over her. Staff C brought several bites of food to Resident #18's mouth, all while standing over her, as well as the glass for a drink. Staff C stood over the resident to assist with eating until 11:59 AM. At 12:03 PM, Staff C returned to the resident, stood over them, put food on a fork and brought it to their mouth. During an observation 9/17/25 beginning at 11:45 AM of lunch service in the CCDI unit, Resident #18 ate her meal independently. During an interview 9/17/25 at 12:35 PM, the Director of Nursing (DON) stated they expected the staff to sit down next to residents while assisting them during meal services and not hover over them as they assisted them with eating and drinking for dignity purposes. Review of the facility policy Promoting/Maintaining Resident Dignity During Mealtimes, undated, documented it is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life. All staff will be seated, if possible, while feeding a resident.	F0550		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the	F0644		

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F0644 SS = D	Continued from page 3 PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interviews and policy review, the facility failed to submit a Level 1 and a Level II Preadmission Screening and Resident Review (PASRR) evaluation to the appropriate state-designated authority prior to the expiration date for 2 of 2 residents reviewed for PASRR (Resident #4 and Resident #38). The facility reported a census of 58 residents. Findings include: 1. The Minimum Data Set (MDS) dated 6/20/25 indicated Resident #4 had diagnoses of anxiety disorder, depression and bipolar disorder. Resident #4's PASRR completed 10/28/24 provided authorization for short-term nursing facility services approved for 60-days for convalescent care. The report also indicated that re-screening must occur by or before the 60th day if the individual would remain in the nursing facility beyond the current authorized timeframe. The due date of the Follow-up level I PASRR would need done on or before 12/26/24. In an interview on 9/16/25 at 1:05 PM Staff A, Social Worker (SW), stated PASRR assessments are typically done by the hospital before they first arrive at the facility. She typically performed them when there is a change in condition or a new diagnosis, especially for Level II PASRR residents. Staff A stated the authorized PASRR company tracked when the next PASRR is due online. Upon request of Staff A reviewing Resident #4 online, she described Resident #4 as a short term PASRR that she missed and is overdue for one now. Staff A reported the last PASRR performed as 10/28/24 and only approved for 60 days. Added Resident #4 should have a new level I PASRR completed just after the first of the year, and she planned to complete it soon.	F0644		

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F0644 SS = D	Continued from page 4 In an interview on 9/17/25 at 9:00 AM Staff A explained she currently worked on Resident #4's new PASRR level I. She stated she would expect to get a reply in 12-24 hours but expected Resident #4 would be a level II. She added that if Resident #4 received a level II indicated, someone would come out and evaluate her on site. When questioned about Resident #4's PASRR status as level I or level II, Staff A responded neither as she is out of compliance. A document titled Resident Assessment -- Coordination with PASARR Program stated that the Social Services Director, or designee, shall be responsible for keeping track of each resident's PASRR screening status, and referring to the appropriate authority. 2. The MDS dated 7/16/25 documented Resident #38 had a BIMS score of 7, indicating severe cognitive impairment. The resident had diagnoses to include medically complex conditions, anxiety disorder and bipolar disorder. The MDS documented the resident was taking high risk drug classes to include antipsychotic and antianxiety medications in the look back period. The Care Plan for Resident #38, with an initiation date of 8/24/23, documented they received a short-term nursing facility approval in PASRR which expired 11/26/23, as a result all PASRR identified community placement supports needed addressed as part of the resident's Care Plan in addition to any specialized and rehabilitative services. Clinical record review of facility submitted Level II PASRR completed by the authorized facility for Resident #38 documented a determination of a short-term Level II approval on 6/29/23, with a time limited approval of 11/26/23. Clinical record review for Resident #38 lacked a new Level II PASRR submission before or after the approval end date of 11/26/23. During an interview on 9/16/25 at 2:30 PM, Staff A verified the date of the last Level II PASRR completed for Resident #38 as June 2023, with a Level II short term approval that expired on 11/26/23. Staff A acknowledged another PASRR didn't get completed in November of 2023 or since then. Staff A explained they expected this completed and submitted by the expiration date in November 2023.	F0644		
F0657 SS = D	Care Plan Timing and Revision	F0657		

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F0657 SS = D	Continued from page 5 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interview, and policy review, the facility failed to fully review and revise the comprehensive Care Plan for 2 of 16 residents (Resident #4 and Resident #38) sampled for Care Plan review. The facility reported a census of 58 residents. Findings include: 1. Resident #4 had a Preadmission Screening and Resident Review (PASRR) completed on 10/28/24, which provided authorization for short-term nursing facility services approved for a 60-days for convalescent care. The report also indicated that re-screening must occur by or before the 60th day if the individual would be remaining in the nursing facility beyond the current	F0657		

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F0657 SS = D	Continued from page 6 authorized timeframe. Follow-up level I PASRR would be due on or before 12/26/24. The Care Plan initiated on 5/9/25 for Resident #4 referenced PASRR level II 3 times including goals and interventions. It was noted, after speaking with Staff A, SW, that the PASRR level II references on the Care Plan were cancelled on 9/17/25. In an interview on 9/16/25 at 1:05 PM Staff A, SW stated PASRR assessments are typically done by the hospital before they first arrive at the facility. She typically performs them when there is a change in condition or a new diagnosis, especially for Level II PASRR residents. Staff A, SW stated that Maximus tracks when the next PASRR is due online. This surveyor requested she pull up Resident #4 online. Staff A, SW stated that she was a short term PASRR that she missed and is due for one now. Stated the last PASRR performed was 10/28/24 and was only approved for 60 days. Added that she should have been due just after the first of this year and she plans to do soon. In an interview on 9/17/25 at 9:00 AM Staff A stated that 3 references to PASRR level II on the Care Plan is probably from her previous stays. When questioned if they should be on the current Care Plan given Resident #4's status, she stated no they shouldn't. An undated document titled Care Plan Revisions Upon Status Change instructed to review and revise the Comprehensive Care Plan as necessary, when a resident experiences a status change. 2. The Minimum Data Set (MDS) dated 7/16/25 documented Resident #38 had a BIMS score of 7, indicating severe cognitive impairment. The resident had diagnoses of medically complex conditions, anxiety disorder and bipolar disorder. Clinical record review of facility submitted Level II PASRR for Resident #38 documented a determination of a short-term Level II approval on 6/29/23, with a time limited approval of 11/26/23. The PASRR determination explanation section documented the resident met PASRR criteria for serious mental illness which had led to significant symptoms that impact daily functioning and the need for intensive supports. The PASRR included what services and supports the nursing facility staff were required to provide, which included the following specialized services: ongoing psychiatric medication management, individual therapy by a licensed behavioral	F0657		

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F0657 SS = D	Continued from page 7 health professional, rehabilitative services and community placement supports. The Care Plan for Resident #38, with a revision date of 9/6/23, included a focus area for PASRR. The Care Plan documented PASRR had identified the resident was in need of specialized services due to mental illness and to assist the resident to achieve optimal functioning and recovery. The interventions/tasks section did not provide the name of the therapist or the frequency of therapy. The Care Plan further documented the resident had been given a short-term nursing facility approval in PASRR which expired 11/26/23, as a result all PASRR identified community placement supports needed addressed as part of the resident's Care Plan in addition to any specialized and rehabilitative services. During an interview 9/16/25 at 3:25 PM, Staff A stated she completed the residents' Care Plans on PASRR. In addition, she updated and revised those sections. She acknowledged Resident #38's Care Plan section didn't get updated since 2023 regarding the PASRR recommendations or revised to be person-centered. The facility used a template for PASRR, and the template didn't get updated for specific interventions for Resident #38. Staff A stated they expected that updated, revised, be person centered and comprehensive. Staff A acknowledged this didn't happen with Resident #38's Care Plan.	F0657		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent	F0693		

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F0693 SS = D	Continued from page 8 complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical chart review and staff interview the facility failed to check placement for jejunostomy tube (j-tube or a small tube inserted through the stomach to provide nutrients and potential medication) for 1 of 1 resident (Resident #1). The facility reported a census of 58 residents. Findings included: The Minimum Data Set (MDS) dated 7/25/25 for Resident #1, documented the Brief Interview for Mental Status (BIMS) scored a 13 indicating intact cognition. The MDS identified diagnoses of quadriplegic (inability to move their upper and lower body on their own), seizure disorder, and peripheral vascular disease (poor blood flow through the vessels). The MDS indicated Resident #1 received nutrition through a jejunostomy feeding tube. The Care Plan dated 5/20/25 indicated to check for tube placement and gastric contents/residual volume per order. On 9/17/25 at 11:10 AM observed Staff B, Registered Nurse, (RN), administer medications and fluids via the j-tube. Staff B failed to check placement of the j-tube prior to administering the medications or fluids. Interview on 9/17/25 at 12:15 PM Staff B, acknowledged she didn't check placement prior to administering the fluids. Staff B verified the nurse would check placement by pulling back the stomach contents. The facility policy dated 5/5/25 named Verifying Placement of Feeding Tube identified the practice of the facility as to ensure proper placement of feeding tubes prior to beginning a feeding, flushing the tube, or before administering medications via feeding tube. To verify tube placement, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube. Notify supervisor and/or physician of abnormal findings, or using a stethoscope, listen for placement. Place the stethoscope's diaphragm flat on the patient's abdomen, next to the tube site. Quickly inject air (5-10	F0693		

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F0693 SS = D	Continued from page 9 milliliters "ML") down the tube, listen for a "swoosh" or "gurgling" sound. On 9/17/25 at 12:50 PM the DON stated they expected the staff to follow the physician orders on the medication administration sheet and to check placement prior to administering fluids.	F0693		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F0880		

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F0880 SS = D	Continued from page 10 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, document review and staff interviews the facility failed to provide appropriate infection prevention practices by not following guidelines for enhanced barrier precautions (EBP) for 1 out of 1 resident reviewed (Resident #1). The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) dated 7/25/25 for Resident #1, documented the Brief Interview for Mental Status (BIMS) scored a 13 indicating intact cognition. The MDS listed Resident #1 utilizes an external catheter. The MDS identified diagnosis as a quadriplegic, seizure disorder, and peripheral vascular disease. The MDS also documented that the resident received nutrition through a jejunostomy feeding tube (j-tube).	F0880		

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Crestview Nursing & Rehab	**2401 South Des Moines Street , Webster City, Iowa, 50595**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 11 Resident #1's Care Plan dated 7/25/25 instructed staff to wear EBP due to their indwelling j-tube and urinary catheter. On 9/17/25 at 11:10 AM observed Staff B, Registered Nurse (RN), complete a treatment to Resident #1's j-tube site. As Staff B did, they treatment, they failed to wear EBP. Interview on 9/17/25 at 12:15 PM Staff B acknowledged she should have worn EBP while doing the treatment. The facility policy named Enhanced Barrier Precautions revised 5/8/24 defined the purpose as to reduce the risk of transmission of multidrug-resistant organisms (MDRO) in the facility. High Contact activity included activities that place the resident and the person helping them in close physical contact that increases the risk of transmission of MDRO between the resident and health care provider. These activities included device care such as central line, urinary catheter, feeding tube, and tracheotomy/ventilator. Indwelling devices include any devices that are inserted into the resident and have contact with the external air such as foley catheters, central lines, tracheostomies, feeding tubes, or drains. Personal protective equipment (PPE) used to reduce the risk of exposure to and transmission of microorganisms. EBP includes the use of gowns and gloves. In instances where splashes/sprays are anticipated, face protection (mask or respirator) and eye protection (goggles or face shield) should also be applied. Interview on 9/17/25 at 12:50 PM the Director of Nursing (DON) stated they expected the staff to wear EPB for residents with feeding tubes and catheters.	F0880		

Crestview Nursing and Rehabilitation

Plan of Correction

November 20, 2025

Accept this Plan of Correction as Crestview Nursing and Rehabilitation's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement of the deficiencies cited but is submitted because it is required by state and federal law.

Date of Correction: November 20, 2025

F550

1. It is Crestview's policy to comply with all resident rights and provide quality care to all our residents.
2. In regard to residents #18 and #6 and all other residents in similar situations, staff education has been completed for assisting/feeding residents at meals.
3. The Director of Nursing and ADON will complete audits at meals and observe feeding monthly for the next 3 months then quarterly x 4 quarters.
4. QAPI team will monitor compliance on quarterly basis for a year. The quality assurance audits will be reviewed by the facility's QAPI committee. Any issues identified will be immediately addressed.

Date of Correction: November 20, 2025

F644

1. It is Crestview's policy to make sure that all residents have a completed PASARR and that they are kept up to date and completed on time.
2. In regard to Residents #4 and #38 and all other residents in similar situations, staff education has been completed with Social Services regarding PASARR and following due dates keeping them current and active.
3. The Administrator will complete monthly audits to review PASARR and dates.
4. QAPI team will monitor for compliance quarterly for a year. The quality assurance audits will be reviewed by the facility's QAPI committee. Any issues identified will be immediately corrected. Administration will review for overall compliance with this regulation.

Date of Correction: November 20, 2025

F657

1. It is Crestview's policy to make sure that all residents have care plans that include any PASARR recommendations and that they are up to date with current interventions and those interventions are reviewed at care conferences and changed as needed.
2. In regard to Residents #4 and #38, education was provided to social worker and nursing staff on updating care plans and making revision and updates as needed.
3. The Administrator will complete monthly audits on care plans for 3 months.
4. QAPI team will monitor compliance on quarterly basis for a year.

Date of Correction: November 20, 2025

F693

1. It is Crestview's policy to check placement for tube feeding before utilizing the tube for medications or feeding.
2. In regard to Resident #1, education was provided to Nurses on checking placement on feeding tubes and nurses were checked for competency.
3. The Director of Nursing and ADON will complete monthly audits for 3 months then quarterly to check for compliance.
4. QAPI team will monitor compliance on a quarterly basis for a year.

Date of Correction: November 20, 2025

F880

1. It is Crestview's policy to follow enhanced barrier precautions as a means of infection control.
2. In regard to Resident #1 and all other residents in similar situation, staff have been re-educated on enhanced barrier precautions.
3. The Director of Nursing and ADON will complete monthly audits for 3 months then quarterly to check for compliance.
4. QAPI team will monitor compliance on a quarterly basis.